IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 10, 2006

FILE COPY

Thair Pond
Tomorrow's Hope – Eagle
1655 Fairview Ave Ste 100
Boise, ID 83702

RE: Tomorrow's Hope - Eagle, Provider #13G047

Dear Thair Pond:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded at your facility, Tomorrow's Hope - Eagle, on July 24, 2006 – July 28, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 23, 2006**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

NICOLE WISENOR, QMRP
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

NW/mlw

Enclosures

TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Nicole Wisenor, QMRP
Health Facility Surveyor
Non-Long Term Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0036

August 22, 2006

RE: Plan of Corrections

Dear Nicole Wisenor,

Please find attached our Plan of Correction for deficiencies found during your recent survey of our Eagle ICF/MR. If you require more information or assistance, please contact me at the above address and phone number.

Thank you for your courtesies during your recent visit.

Sincerely,

Thair Pond
Administrator

Cc: file, Eagle, PD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your recertification survey. The surveyors conducting your survey were: Nicole Wisenor, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations/words used in this report are: ADHD - Attention Deficit Hyperactive Disorder BID - Twice Daily IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse PRN - As Needed Para - QMRP - Assistant Qualified Mental Retardation Professional	W 000	RECEIVED AUG 23 2006 W234/FACILITY STANDARDS Program implementation Instructions for identified Residents will be rewritten to ensure Staff have sufficient information to correctly implement programs Para & Responsible by 8/30/06	
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 4 of 6 individuals (Individuals #1, #2, #4, and #6) whose training programs were reviewed. This resulted in lack of instructions for staff regarding implementing the program and the potential for inconsistent application of techniques and interventions. The findings include: 1. Individual #1's Medical and Social Assessment,	W 234	Initial programs and implementation instructions to be reviewed to ensure staff will have adequate direction to properly run programs prior to implementation. All instructions will be reviewed using Periodic Service Review (PSR) Prior to implementation. Methods and implementation instructions of programs are to be done at least quarterly during Quality Assurance Reviews. Professional staff to be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas S. Pond — TITLE: Administrator — (X6) DATE: 8/30/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 1 dated 7/13/06, stated he was a 26 year old male whose diagnoses included severe mental retardation, major depression, ADHD, intermittent explosive disorder, obsessive compulsive disorder, expressive language disorder, bone marrow disorder, lymphedema, and cellulitis. a. An observation was conducted on 7/25/06 from 6:34 - 7:34 a.m. At 7:00 a.m. Individual #1 was taking his medications. The staff presented the bubble packs one at a time, stated of the name and purpose of each medication, then positioned the bubble pack over a paper cup. Individual #1 punched the medication from each bubble pack into the cup. Once all mediations were punched into the paper cup, Individual #1 used the cup to place the medications in his mouth and swallowed multiple times. Individual #1 began coughing and the staff stated "Are they sticking in your throat this morning?" Water was not present or offered during the observation. Individual #1's medication administration program stated he "is able to remove pills from the bubble pack and will ingest them independently ([Individual #1] takes them without water)." The program included instructions to staff regarding Individual #1 stating the purpose of the medication, but did not include specific instructions to staff regarding how Individual #1 was to take his medications. Additionally, the program stated "After [Individual #1] removes the medication from the bubble pack, have him take his cup/bowl and go upstairs." The program did not provide staff with sufficient information regarding how to set up the area for Individual #1's medication program, specific steps	W 234	Trained on Review Process QMRP by S Para 9 + QMRP Responsible by	8/30/06 9/10/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 2 staff needed to follow during the medication pass, or how to address issues of medications sticking in Individual #1's throat. During an interview conducted with the LPN, Para-QMRP and Program Director on 7/20/06 at 1:00 p.m., the LPN stated fluids always need to be offered during medication passes, and a water pitcher should always be available. The Para-QMRP stated specific instructions to staff were not included in the program. b. Individual #1's file included an information sheet which described Lymphedema as a disorder "caused by the lymph valves in the body not working properly. The valves do not open and close correctly, so the lymph fluid is unable to circulate causing the fluid to pool in certain areas such as legs , [sic] abdomen , [sic] arms..." His Medical and Social Assessment, dated 7/13/06, stated "Lymphedema causes chronic Cellulitis in the lower extremities which requires [Individual #1] to wear support hose to prevent blood clots." During observation on 7/24/06 from 3:10 - 4:10 p.m. it was noted that Individual #1's legs were swollen, but he was not observed wearing support hose. During observation on 7/24/06 from 5:05 - 6:05 p.m. Individual #1 was observed to be wearing support hose, although the hose had a hole approximately 1 inch by 3 inches behind the left knee, as well as a run approximately 3 inches in length from the outside of the left knee down. During observation at the day treatment program on 7/25/06 from 9:52 - 10:40 a.m. Individual #1 was observed to be wearing his support hose, although the same holes noted on 7/24/06 were present, as well as a hole approximately 1 inch by	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 3 2 inches on top of the left ankle. At 10:36 a.m. Individual #1 took his right shoe off, sat on the floor and began to remove his support hose. A staff came to assist Individual #1 with removing the hose. Individual #1's Instructional Plan for support hose stated "[Individual #1] is to wear the hose every day." The plan further stated "In the afternoon if they are hurting [Individual #1] staff may take off for a little while." The plan did not specify the length of time Individual #1 was to wear the hose, or how long they could remain off during the day. During an interview on 7/27/06 at 1:00 p.m., when asked about Individual #1's need for and use of support hose, the LPN stated he should ideally wear them for 6 - 8 hours. The LPN stated the physician has not given a specific period of time, and that Individual #1 only wants to take the hose off when they are hurting him. Additionally, the LPN stated she would expect staff to cue Individual #1 to put the hose back on about once an hour. The program did not provide staff information needed regarding the time Individual #1 needed to have support hose on to prevent complications from his Lymphedema. Additionally, the plan did not provide instructions to staff on what to do when Individual #1 wanted to remove the support hose or when and how often to cue Individual #1 to reapply the hose. The facility failed to ensure Individual #1's programs provided sufficient information to staff. 2. Individual #4's Medical and Social	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 4 Assessment, dated 5/9/2006, stated he was a 15 year old male whose diagnosis included mild mental retardation, post traumatic stress disorder, attention deficit hyperactivity disorder, intermittent explosive disorder, and oppositional defiant disorder. An observation was conducted on 7/25/06 from 6:34 - 7:34 a.m. At 7:23 a.m. Individual #4 was observed taking medications in the medication area with the assistance of a staff. Individual #4 was able to repeat the name and purpose of each medications with assistance of staff, and swallowed the medications without water. Individual #4's program for Medication Training, dated 5/12/06, stated "[Individual #4] removes the medication from the bubble pack independently and will ingest medications." However, the plan did not include specific instructions to staff as to what steps Individual #4 needed to complete to take his medications. During an interview conducted with the LPN, Para-QMRP and Program Director on 7/20/06 at 1:00 p.m., the LPN stated fluids always need to be offered during medication passes, and a water pitcher should always be available. The Para-QMRP stated specific instructions to staff were not included in the program. The facility failed to ensure Individual #4's medication program provided sufficient information to staff. 3. Individual #2's IPP, dated 11/16/05, stated she was a 33 year old female with diagnoses which included moderate mental retardation,	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 5 schizophrenia, obsessive compulsive syndrome, and atypical psychotic disorder. a. Her behavior plan, dated 10/11/05, stated she engaged in "agitation" defined as screaming, spitting, hitting and pounding objects. The plan stated Individual #2's agitation episodes were "infrequent and of short duration." Staff were to do the following when Individual #2 became agitated: - "Tell [Individual #2] that it is okay to do something later (teach her how to Escape)." - "Allow [Individual #2] time to calm down (she likes to water, color, draw, etc.)." - "Talk to [Individual #2] after she is calm about how to ask to do something later (Again, teach her how to escape)." - "Allow [Individual #2] time to do something later when she asks (Let her Escape)." The plan did not include any further instructions to staff on how or when to implement the intervention strategies. When asked about the plan, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:50 p.m., the Para-QMRP stated staff were to immediately interview when Individual #2 began to show signs of agitation. The Para-QMRP stated after talking with Individual #2 staff were to walk away. If Individual #2 was still agitated staff were to talk with her again. The plan's instructions were not sufficient to ensure the intervention strategy was consistently implemented. 4. On 7/24/06 at 3:47 p.m., Individual #6 was	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 6 observed taking her medications. Staff provided her with hand over hand assistance to obtain a Dixie cup, hand over hand assistance to pour 2 Tylenol from a pill bottle into the cap of the bottle, and hand over hand assistance to pour the pills from the bottle cap into the Dixie cup. Individual #6 then took the pills from the cup and placed them in her mouth. Individual #6 continued to hold the pills in her mouth and staff prompted her to swallow. Staff did not offer Individual #6 fluids to help her swallow the medication. Individual #6's "Medication Administration Training" plan, dated 3/10/06, stated staff were to "use the levels of assist" to prompt Individual #6 to sit in a chair to take her medications. The plan did not include instruction to staff on how Individual #6's medications were to be administered (i.e. following the levels of assistance for each step of administration, whether or not she was to be offered fluids, etc.). When asked about the plan, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:50 p.m., the Para-QMRP stated the plan did not include instructions as to how the medications were to be administered. The facility failed to ensure Individual #6's medication program provided sufficient information to staff.	W 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure IPPs described relevant interventions to support independence for 1 of 4 sample individuals (Individual #1) whose records were reviewed. This resulted in insufficient information being available to staff related to an individual's falls. The findings include: 1. Individual #1's Medical and Social Assessment, dated 7/13/06, stated he was a 26 year old male whose diagnosis included severe mental retardation, major depression, ADHD, intermittent explosive disorder, obsessive compulsive disorder, expressive language disorder, bone marrow disorder, lymphedema, and cellulitis. Individual #1 was observed to be unsteady on his feet during observations conducted on 7/24/06 from 3:10 - 4:10 p.m. and 5:05 - 6:05 p.m., and on 7/25/06 from 6:34 - 7:34 a.m. and 9:52 to 10:40 a.m. During observation on 7/25/06 at 7:19 a.m., Individual #1 tripped over a chair leg in the dining room while taking milk, a bowl of cereal, and a plate to the table. He stumbled and caught himself with staff assistance, using the table for support. Individual #1's record documented the following related to his falls and risk of falling: - 2/22/06: A fall risk assessment was completed	W 240	W240 Identified Resident will have fall Protocal and Staff Instructions written and Implemented by Para 9 by Initial and annual IPPs to be reviewed to ensure Resident needs are identified and addressed. Periodic Service Review to be used as Quality Assurance Methodology. Reviews of Resident needs and programs to be at least Quarterly during QA process. To ensure changes in Resident needs are Reflected on IPPs and addressed as needed PSR to be utilized Para 9 and QMRP Responsible by	8/30/06 09/12/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	Continued From page 8 which stated he had an overall score of 5, with 10 or above representing a high risk for falls. - 5/1/06 - 5/31/06: 4 falls were documented. - 6/1/06 - 6/31/06: 54 falls were documented. - 6/21/06: A fall risk assessment was completed which stated he had an overall score of 12, with 10 or above representing a high risk for falls. - 7/1/06 - 7/19/06: 22 falls were documented. An interview was conducted with the LPN, Para-QMRP and Program Director on 7/20/06 at 1:00 p.m. When asked about Individual #1's falls, the Para-QMRP stated falls had been addressed by the IDT. She stated the IDT had assessed the falls and thought they were related to Individual #1's medication changes. The Para-QMRP stated staff had been trained (as evidenced by in-service notes dated 6/3/06 and 6/6/06) to monitor Individual #1 for times when he appeared to be unsteady and to catch him if he began to fall. When asked about a formal fall protocol for Individual #1, the Para QMRP stated a formal fall protocol had not been put in place. The facility failed to assure Individual #1's IPP included information specific to his falls that would allow any staff person working with him to provide services and supports necessary to assist Individual #1 in maintaining independence and safety.	W 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 4 individuals (Individuals #2 and #3) whose medication plans were reviewed. This resulted in individuals receiving behavior modifying drugs without comprehensive plans that identified drug usage and how they may change in relation to progress or regression. The findings include: 1. Individual #2's IPP, dated 11/16/05, stated she was a 33 year old female with diagnoses which included moderate mental retardation, schizophrenia, obsessive compulsive syndrome, and atypical psychotic disorder. Her physician's orders, dated 6/28/06, stated she was to receive Clozaril 100 mg (one and a half tabs in the morning, 1 tab in the p.m., and 2 and a half tabs in the evening) and Luvox 50 mg (one tab twice daily). She also had an order for Lorazepam 1 mg as needed for agitation and insomnia. Individual #2's medication plan, dated 4/24/06, included the following: a. Her medication plan stated she received	W 312	W312 Physician, Nurse, Para Q and QMRP will review identified resident medications and programs and modify them as needed to ensure there are comprehensive plans reflecting usage of Medications based upon Residents progression and regression. Nurse & Para Q Responsible by 09/15/06 Medications used for control of inappropriate behavior will be reviewed to ensure it is used only as part of the resident IPP that is directed specifically towards reduction and eventual elimination of the behaviors for which the medication was prescribed. Reviews to be prior to implementation and include matching diagnosis with prescription, documentation and data collection, and criteria for reduction, increase, or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 10 Luvox for her obsessive compulsive syndrome. The plan stated the medication had been initiated "on 9/12/97 as a replacement for Anafranil. Anafranil has a side effect of weight gain and [Individual #2's] weight was a continuing concern. [Individual #2] had a trail period off the anti-depressant (Anafranil 6/24/97 to 8/04/97) and had significant increases in agitation and a loss of interest in routine daily programming, along with loss of skills. The treatment team, [Individual #2's] Guardians (Parents), and [psychiatrist's name] do no [sic] believe it is in [Individual #2's] best interest to have another trial period off the Luvox." The plan further stated "Luvox is waived from the reduction trial." The plan did not include data which showed a direct relationship between past attempts at withdrawal and an increase in the targeted behavior or symptoms. Further, the plan did not document previous programmatic interventions and Individual #2's response to those interventions or other environmental factors which may have contributed to Individual #2's past increases in obsessive compulsive behaviors. Additionally, Individual #2's IPP did not include an objective or plan to assist Individual #2 to reduce, ameliorate, compensate or eliminate her obsessive compulsive behaviors. When asked about the plan, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:00 p.m., the Para-QMRP stated Individual #2 did not have a plan which addressed her obsessive compulsive behaviors. b. Individual #2's medication plan stated she	W 312	Elimination of Medication. Medication needs and usage to be reviewed at least Quarterly during QA process utilizing PSR. QMRP responsible by	08/16/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 11 received Clozaril for Schizophrenia. However, her IPP did not include an objective or plan to assist Individual #2 to reduce, ameliorate, compensate or eliminate the symptoms of her schizophrenia. When asked about the plan, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:40 p.m., the Para-QMRP stated Individual #2 did not have a plan which addressed her schizophrenic symptoms. c. Individual #2's record included a protocol, dated 4/13/06, for her prn Lorazepam (Ativan). The protocol stated she was to receive "Ativan 1 mg, 1 tab BID PRN for agitation and 1 tab if not in bed asleep by 9:30 p.m., may repeat 1 time if [Individual #2] is awake before 4:00 a.m." Individual #2's record did not identify how the prn usage may change in relation to progress or regression in her agitation and insomnia. Further, Individual #2's IPP did not include an objective or plan to address her insomnia. When asked about a plan that identified how the prn Ativan usage may change, the Para-QMRP stated on 7/26/06 at 10:35 a.m., criteria for a reduction of the prn Ativan had not been established. When asked about a plan to address Individual #2's insomnia, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:45 p.m., the Para-QMRP stated a plan had not been developed. The facility failed to ensure Individual #2's	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 12 behavior modifying drugs were used only as a comprehensive part of her IPP specifically directed towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. 2. Individual #3's IPP, dated 3/24/06, stated she was a 26 year old female with diagnoses which included profound mental retardation, autistic disorder, seizure disorder, and pervasive developmental disorder. Her physician's orders, dated 6/28/06, stated she was to receive Zoloft 50 mg (1 tab in the morning) and Risperdal (2 mg in the morning and 2.5 mg in the evening). Individual #3's medication plan, dated 7/26/06, stated she received Zoloft and Risperdal for aggression, self-injurious, and obsessive behaviors associated with her autistic disorder. Her medication plan included the following: a. Her medication plan stated Zoloft "originally started 02/1997: [Individual #3's] Zoloft has gone as high as 150 mg (12/98) without benefit, and as low as 12.5 mg which had an effect of increased behavior. It was reduced down to 50 mg at the time Risperdal was introduced. Behaviors were at the lowest we have seen them in years. On 1/20/2000 Zoloft was decreased to 37 1/2 mg in the AM. This dose appears to be optimal. Zoloft is waived for medication reduction. It is contraindicated at this time...Zoloft is waived from reduction trial." The plan did not include data which showed a direct relationship between past attempts at withdrawal and an increase in the targeted behavior or symptoms. Further, the plan did not document previous programmatic interventions	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 13 and Individual #3's response to those interventions or other environmental factors which may have contributed to Individual #3's past increases in behaviors. Additionally, Individual #3's IPP did not include an objective or plan to address her obsessive behaviors. When asked about a plan to address Individual #3's obsessive behaviors, during an interview conducted with the Program Director, LPN and Para-QMRP on 7/27/06 at 3:30 p.m., the Para-QMRP stated a plan had not been developed. The facility failed to ensure Individual #3's behavior modifying drugs were used only as a comprehensive part of her IPP specifically directed towards the reduction of and eventual elimination of the behaviors for which the drugs were employed.	W 312		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	MM 197 Refer to W312	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on environmental review it was determined the facility failed to ensure the building and all equipment were maintained in a clean, sanitary manner for 7 of 7 individuals (Individuals #1 - #7). Findings include: 1. An environmental survey of the facility, conducted 7/27/06 at 12:04 p.m., showed the following concerns: a. The bedroom shared by Individuals #4 and #7 had three patches on the wall which needed paint, one approximately 1 foot by 1 foot and located by the door, was approximately 2 foot by 2 foot and located above individual #4's bed, and one approximately 1 foot by 1 foot and located on the back wall. b. Individual #4's pillow case had what appeared to be spots of blood on it.	MM380	MM380 All Identified deficiencies to be cleaned/replaced/or Repaired as needed to Comply. Para Q Responsible by 9/30/06 RECEIVED AUG 23 2006 FACILITY STANDARDS Per Third Pond - The facility will use a maintenance form completed monthly by the Para-Q to report issues of concern. The form will be provided to the Maintenance	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/22/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 1 c. The blinds in the bedroom shared by Individuals #4 and #7 were bent. d. The center support and back wall of the closet in the bedroom shared by Individuals #4 and #7 were scratched, marred and missing paint. e. The toilet tank cover in the bathroom across from Individual #4's bedroom was too big and did not fit. f. The face plate for the light switch in the bathroom across from Individual #4's bedroom was loose. g. The toilet in the bathroom shared by Individuals #2 and #5 was missing the tank lid. h. The blinds in the bedroom shared by Individuals #2 and #5 were covered in dust and dirt and needed cleaning. i. The back wall in the bedroom closet shared by Individuals #3 and #6 was patched and needed paint. j. The window blinds in the bedroom shared by Individuals #3 and #6 had several broken slats. k. The front door to the facility was scratched and marred inside and out and needed paint. l. The front of the kitchen counter facing into the dining area was marred with black marks and needed cleaning. m. The back yard gate was bent. n. The window screens on the bedrooms shared by Individuals #3 and #6, Individuals #2 and #5,	MM380	mean for repair completion and monitored via the form. M. Case, LSW, @MRP, HFS on 9/11/06 @ 2:50 pm.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 2 Individuals #4 and #7, and Individual #1 were bent. o. There were shingles missing from the garage roof. p. There were cobwebs under the eves of the house on all sides. q. The picnic table in the back yard was missing paint on the top and benches. r. The chain guard over the basement window to the north of the back door was loose and needed to be re-stretched on the frame. s. The handrail for the back steps was loose. t. The rain gutters along the garage roof were clogged with leaves and debris. u. Two large pizza pans were black with baked on grease. v. Three of four kitchen drawers to the right of the stove top were broken. w. There was a scoop left inside the Thicket container used by Individual #7. x. There were two ceiling light panel covers in the kitchen, one on each end, that were cracked and broken. y. The living room blinds were bent. z. The ceiling vent closest to the stairway in the basement was loose. aa. There was ice built up on the inside and over	MM380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G047	A. BUILDING _____ B. WING _____	07/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - EAGLE	1057 RUSH ROAD EAGLE, ID 83616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 3 the seal of the chest freezer in the basement.	MM380		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234 and W240.	MM855	MM 855 Refer to W234 + W240	

corrections for 07/28/06 Eagle survey deficiencies.

W234

Program implementation instructions for identified residents will be rewritten to ensure staff have sufficient information to correctly implement the programs
Para Q responsible by 08/30/06

Intitial programs and implementation instructions to be reviewed to ensure staff will have adequate direction to properly run programs prior to implementation. All instructions will be reviewed using Periodic Service Review (PSR) prior to implementation. Methods and implementation instructions of programs are to be done at least quarterly during Quality Assurance reviews.
Professional staffs to be trained on review process by 08/30/06

Para Q and QMRP responsible for completion by 09/10/06

W240

Identified resident will have fall protocol and staff instruction written and implemented by Para Q by 08/30/06

Inital and annual IPPs to be reviewed to ensure resident needs are identified and adddressed. Periodic Service Review forms to be used as Quality assurance methodology.

Reviews of needs and programs to at least quarterly during QA process to ensure changes in Resident's needs are reflected on IPPs and addressed as needed. Periodic Service Reviews to be utilized.

Para Q and QMRP responsible by 09/12/06

W312
Physician, Nurse, Para Q, and QMRP will review identified resident's medications and programs and modify them as needed to ensure there are comprehensive plans reflecting usage of medications based upon resident's progression and regression.

Nurse and Para Q responsible by 09/12/06

Medication used for control of inappropriate behavior will reviewed to ensure it is used only as part of the resident's IPP that is directed specifically towards reduction and eventual elimination of the behaviors for which the medication is prescribed. Reviews to be prior to implementation and include matching diagnosis with prescription, documentation and data collection, and criteria for reduction, increase, or elimination of medication.

Medication needs and usage to be reviewed at least Quarterly during QA process utilizing PSR

QMRP responsible by 09/12/06

STATE

MM197 Refer to W312

MM380 All identified deficiencies to be cleaned, replaced, or fixed as needed to comply. Para Q responsible by 09/30/06

MM855 Refer to W234 and W240